YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

This **must be** completed - legibly - and signed in all areas by both the player and his/her parent or guardian. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential.
By signing this form the participant affirms having read and agreed to the terms and conditions listed below.

Club: Kansas Rise Volleyball Club Team Name: _____

First Name: _____ Last Name: _____ Birth Date: _____ Age: ____ ☐ Male ☐ Female

Primary Contact: Parent or Guardian
Name: _____
Address: _____ City, State & Zip: _____
Primary Phone: _____ Alternate Phone: _____

Secondary Contact: ☐ **Parent/Guardian** ☐ **Other** _____
Name: _____
Primary Phone: _____ Alternate Phone: _____

Primary Insurance Co: _____ Primary Group/Policy # _____ / _____
Family Physician Name: _____ Physician Phone: _____

Please elaborate on any medical conditions of which we should be aware: _____

Please list any medications currently being taken: _____

In the past 24 months, have you been tested, diagnosed and/or treated for a concussion: ☐ Yes ☐ No

If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome: _____

Please list any allergies (write NONE if no allergies): _____

Participant Signature: _____ Date: _____
(regardless of age):

Participant, _____ , has my permission to participate in training, competition, events, activities and travel sponsored by USA Volleyball or any of its Regional Volleyball Associations (RVAs). I approve of the leaders who will be in charge of this program. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Parent/Guardian Signature: _____ Date: _____

Relationship to Participant: _____

If, during the course of my daughter's/son's activities in volleyball, she/he should become ill or sustain an injury, I hereby **authorize** you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.
Parent/Guardian Signature: _____ Date: _____

OR

I **do not authorize** emergency medical/dental care for my daughter/son.
Parent/Guardian Signature: _____ Date: _____